

**VISN:** Atlanta Network (VISN 7)

**Facility Name:** Central Alabama Veterans Health Care System (619)



**Affected Facilities:** Montgomery Campus – Montgomery, AL

### **Executive Summary:**

The Central Alabama Veterans Health Care System (CAVHCS) was established in 1997 as a result of the integration of two VA medical centers, the Montgomery VAMC (west campus) and Tuskegee VAMC (east campus). Since the integration, the duplication of inpatient services between the two sites has been eliminated and the two divisions are entirely complementary. Since December 2002, all medical and surgical beds have been completely consolidated at the Montgomery campus, while the Tuskegee campus (approximately 40 miles away), houses all mental health, nursing home, domiciliary and rehabilitation beds.

VHA's "realignment" proposal for CAVHCS West was to convert Montgomery to an outpatient-only facility (business hours only). VISN 7 prepared a concept paper that addressed how this could best be accomplished. Due to the remote and rural location of the Tuskegee facility, moving medicine and surgery there is not a viable option. Moving the workloads to VAMC Atlanta and/or VAMC Birmingham would not be realistic either, considering the strains already placed on those two space-bound medical centers, which are struggling with how to meet their own space needs through 2022 (with leases, constructed additions, pushing workload to new and current CBOCs, etc.). Therefore, VISN 7 submitted a preliminary CAVHCS West "realignment" concept paper that responded with a scenario to contract out inpatient medicine/surgery and after-hours emergency workloads to community hospitals.

In response to VISN 7's preliminary concept paper, the draft National CARES Plan stated, "the proposal to convert Montgomery to an outpatient-only facility and to contract out inpatient care requires further study." This realignment package fleshes out the "100% contract" option. It also presents several additional scenarios – 1) status quo (an option required for all realignment packages), 2) the Market Plan that VISN 7 already submitted for CAVHCS, and 3) a new recommended alternative, "Market Plan plus DoD Sharing," whereby CAVHCS West would sell inpatient and outpatient services to nearby Maxwell AFB (within seven miles of CAVHCS West), Lyster US Army Hospital, Ft. Rucker, Alabama (about 20 miles from the CAVHCS-operated CBOC in Dothan, AL), and Martin Army Hospital, Ft. Benning, Georgia (located about 8 miles from the CAVHCS-operated CBOC in Columbus, GA), using available DoD space to meet all space needs. Since we only have firm workload estimates from Maxwell AFB at this time, this analysis does not include workload projections for Lyster and Martin Army Hospitals.

CAVHCS serves 39 counties in the central and southeastern portions of Alabama and western Georgia with an estimated veteran population of 144,481. The CARES model projects that increasing inpatient and outpatient workload over the next 20 years will significantly impact CAVHCS West. CARES data projections indicate a peak in inpatient acute medicine and MICU workload in FY2012, with a required capacity of 51 beds, and

then decreasing to 42 beds required in FY2022. CAVHCS is also projected to have an increase of 10% in outpatient primary care by 2012 and over 110% in outpatient specialty care over the next 20 years. Additionally, CAVHCS is currently working with the 42<sup>nd</sup> Medical Group of Maxwell AFB, Montgomery, Alabama to merge surgical programs as well as jointly provide a continuum of primary, medicine, and specialty care to Montgomery area veterans and service members. Both CAVHCS and DoD are eager to continue implementing this comprehensive continuum of “federal” health care in the CAVHCS service area, as well as maximize taxpayer’s dollars through sharing of VA and DoD resources.

CAVHCS is unusual in having three Military Treatment Facilities (MTFs) within its service area. These MTFs are: Lyster US Army Hospital, Fort Rucker, Alabama; Martin Army Hospital, Ft. Benning, Georgia; and the 42<sup>nd</sup> Medical Group, Maxwell AFB, Montgomery Alabama. Commanders of all three MTFs are meeting regularly with CAVHCS leadership exploring sharing opportunities and demonstrated commitment to joint planning for VA and DoD beneficiary services in south and central Alabama and west Georgia. Maxwell AFB has declared their commitment and desire to purchase both inpatient and outpatient services from CAVHCS West. Maxwell’s inpatient needs are projected to be an average daily census (ADC) in medicine of 3.4 and an ADC in surgery of 2.5. Their need for outpatient services (primary care and specialty care) is estimated at approximately 90,000 clinic stops annually. It should be noted that this workload infusion for CAVHCS would generate approximately \$12.3 million dollars in annual revenues for VA. This would be offset, of course, by the incremental costs for CAVHCS to provide these additional services, which are factored into the recurring costs in the supporting spreadsheets.

The **CAVHCS/DoD sharing alternative** was determined to be the preferred option. The analysis of the VHA proposed realignment alternative, status quo alternative, VISN 7 market plan alternative, and CAVHCS/DoD **sharing** alternative resulted in the CAVHCS/DoD **sharing** alternative being selected as the preferred option because it maximizes the use of federal resources (space, equipment and manpower) to provide health care services to veterans and service members in the Montgomery area, while at the same time allowing both VA and DoD to assure high quality of services across the health care continuum. The other alternatives do not favorably compare with the CAVHCS/DoD **sharing** alternative in that they do not respectively achieve all the benefits of the preferred alternative, i.e., maintain quality care coordination, obviate new construction and lease costs, minimize impact on employees, and maximize use of federal resources through sharing arrangements.

Both CAVHCS and Maxwell AFB can realize immediate benefits through this venture since it can be implemented this fiscal year (FY04). CAVHCS’ and Maxwell AFB’s missions and resources are very complementary of each other. Where Maxwell AFB may experience health care staffing shortages as a result of deployments, etc., CAVHCS has the ability to maintain staff to accommodate the workload. On the other hand, while the Montgomery campus is short on space to meet projected workload demand, Maxwell AFB has a large maxi-clinic, recently built in 2000, that is significantly underutilized. By utilizing space at Maxwell AFB, which is within seven miles of the Montgomery campus, CAVHCS could expand outpatient services such as primary care, outpatient diagnostic

services, specialty care and ambulatory surgery to meet projected demand over the next 20 years, obviating the need for new construction and leases (in the current Market Plan). It should be noted that Maxwell AFB has been procuring needed inpatient services from community hospitals at a premium rate. To purchase these services instead from VA, at a discounted rate, would be advantageous to Maxwell. Other advantages to Maxwell include opportunities to maintain clinicians' skills, supporting military readiness. At the CARES Commission's hearings in Atlanta on August 28, 2003, Col. Van Goor, Commander, 42<sup>nd</sup> Medical Group at Maxwell, testified as follows: "... the idea that the 42<sup>nd</sup> Medical Group ... should consider referring its inpatient caseload ... to the VA hospital. The 42<sup>nd</sup> Medical Group closed its own inpatient services in 1999 and has generated nearly 800 active-duty admissions since then, representing nearly 27,000 bed days. Referring these patients to CAVHCS West Campus could potentially save several million dollars over civilian hospital referral. Also, to a limited extent, 42<sup>nd</sup> Medical Group primary care physicians and surgeons could obtain privileges at the VA hospital and follow their own patients there, keeping their inpatient and war-readiness skills sharp and adding enhanced continuity of care to the already high quality of care given to these patients. Air Force nursing staff could also perform inpatient shift work at the CAVHCS West Campus, keeping them fully qualified to deploy as necessary ..." The close proximity of Maxwell AFB to the Montgomery campus also means there would be little to no impact on accessibility to care. Further, it is anticipated that joint planning with the Lyster and Martin US Army Hospitals will also result in sharing of space and services for inpatient and outpatient care. This will further improve access to care for veterans in the Columbus, Georgia, and Dothan, Alabama, areas where CAVHCS currently operates CBOCs.

In addition to CAVHCS-operated beds enabling a higher degree of control over the costs associated with providing quality inpatient care, CAVHCS-provided inpatient care, coordinated as part of the VA care continuum, is superior to the more fragmented approach of contracting for a portion of the care continuum. While cost is an important factor, decisions of this magnitude and impact must take into consideration many other variables as well. Clearly, a major adverse impact would be on a coordinated continuum of care. For example, CAVHCS' current inpatient unit allows the seamless transfer of complex surgical candidates (e.g., cardiac surgery) within the VA system. It is unlikely that patients already in the community would be moved to a VA for surgical intervention. This would be costly for VA and may make surgery aftercare more difficult to coordinate. Additionally, a significant number of CAVHCS' acute medical-surgical admissions consist of patients who are primarily followed in the mental health, geriatrics (including dementia) and substance abuse programs. Currently, care for these patients is closely coordinated and supported/supplemented by mental health and/or geriatrics staff. Moving these patients to community hospitals may be problematic and diminish the quality of care to these patients.

Contracting out inpatient medicine and surgery would also have a deleterious impact on CAVHCS' academic affiliations. For example, CAVHCS has an active Podiatry Program with four podiatry residents. Since the podiatry residents need acute inpatient services to achieve well-rounded training, a Podiatry Residency Program could not be sustained at CAVHCS if these services were not available.

Last, but not least, the CAVHCS/DoD ***sharing*** alternative is congruent with the President's Management Agenda and directly supports Secretary Principi's stated priority to encourage and support VA/DoD sharing initiatives. As indicated in recent statements by Dr. Robert Roswell, Under Secretary for Health, "... acute care services are essential for a robust health care system". Maintaining a high quality continuum of inpatient medicine and surgery services at CAVHCS is in line with Dr. Roswell's desire to improve acute care services in VHA.

**Current environment:** The Montgomery campus is situated on 52 acres, located in a residential community adjacent to a city school property and is approximately five miles east of downtown Montgomery. One-stop access for veterans and their families has been enhanced by the co-location of the VA Regional Office (VARO) building on the southeast corner of the Montgomery campus complex. The VARO also has staff housed on the fourth floor of the Montgomery campus health care facility. This close proximity and sharing arrangement significantly improves the flow of information and consultation between the VARO and CAVHCS. In addition to the main building, the Montgomery campus grounds encompass three freestanding buildings (6, 7 and 8) that are utilized for administrative support staff. Despite their age (1939), all of the Montgomery campus buildings have been well maintained and are in very good condition, having an average condition score of 3.4 on a scale of 1-5, with five being the best. Inpatient medicine and surgery space is in particularly good condition with an average score of 4.0 for medicine and 3.8 for surgery. On the other hand, the Tuskegee campus has an average condition score of 2.5. With minor renovations to reconfigure space for outpatient operations, the Montgomery campus infrastructure is well suited to meet the projected veteran demand for health care over the next 20 years.

**Preferred Alternative:** The preferred alternative is the ***CAVHCS/DoD sharing alternative***. This alternative will retain, strengthen and slightly expand the inpatient medicine and surgery services at the Montgomery campus while continuing to strengthen the partnership with the 42nd Medical Group of Maxwell AFB, Montgomery, Alabama; Lyster US Army Hospital, Ft. Rucker, Alabama; and Martin Army Hospital, Ft. Benning, Georgia. The goal is to jointly provide a continuum of federal health care (to veterans and service members) in the CAVHCS service area, while bringing the Agency-specific reform from the President's Management Agenda (**Coordination of VA and DoD Programs and Systems**) to reality. CAVHCS is currently working with Maxwell AFB to merge surgical programs, and is working toward a sharing arrangement to provide outpatient primary and specialty care, and inpatient medicine and surgery services. These are significant opportunities for DoD sharing, resulting in increased VA revenue streams. Revenue from this sharing arrangement is projected to be approximately \$12.3 million annually.

Currently, the VISN 7 Market Plan for the Montgomery campus includes the requirement for construction of 59,000 new square feet for medicine, specialty care, and ancillary/diagnostic services. Under the preferred alternative, because Maxwell AFB has a significant amount of underutilized state-of-the-art (constructed in 2000) space, the opportunity exists for CAVHCS to utilize this underutilized space to increase its outpatient care capacity and free up space on the Montgomery campus for conversion to inpatient space and improve functionality of outpatient space. Additionally, CAVHCS anticipates

future sharing of space with both Lyster and Martin Army Hospitals. This will further free up space on the Montgomery campus. Therefore, the preferred alternative would obviate all new construction and leases for CAVHCS West.

**VHA Proposed Realignment:** The 100% contract alternative consists of converting the Montgomery campus from a 24/7 operation to an 8-hour/day operation. This scenario entails contracting out 100% of CAVHCS' inpatient medicine and surgery workload to the community, which would require acute inpatient medicine and surgery, and the medical intensive care unit (MICU) being shifted to a contract facility.

The 100% contract alternative would create an inequity in the level of care provided to veterans that CAVHCS serves. Implementation of this alternative would deprive CAVHCS' veterans of VA care while other veterans in VISN 7 and across the country would continue to enjoy the benefits of the second to none VA-delivered care. VA was recently cited in the New England Journal of Medicine for having one of the nation's best health care systems.

Additionally, the 42<sup>nd</sup> Medical Group at Maxwell AFB would have no inpatient backup capacity were CAVHCS' medicine and surgery beds to be closed. Closure of CAVHCS' inpatient medicine and surgery capacity would be a severe blow to this DoD installation, including conflicting with the President's Management Agenda's Agency-specific reform, to coordinate VA and DoD programs and systems, as well as recommendations presented by the President's Task Force (PTF) that **VA and DoD can improve quality, access, and efficiency of health care delivery by pooling resources**, eliminating administrative barriers, and implementing change.

Additional costs would be associated with the 100% contract alternative. These include: 1) a care coordination/contract administration office estimated at \$618,000 annually; 2) after-hours contract emergency care ("Mill Bill") due to closure of current CAVHCS after-hours Life Support Unit, estimated at \$3.3 million annually; and 3) FTE attrition costs (savings in CARES software are calculated immediately upon contracting out, while FTE/salary portion of savings will not occur until full attrition occurs) estimated to begin at \$3.5 million in FY 04 phasing out gradually to reach \$0 in FY 14. All of these costs have been inserted in the cost worksheets.

**VISN 7 Market Plan Alternative:** This alternative calls for new construction to accommodate the significant increase in overall projected inpatient (21.9% increase by 2012) and outpatient (42.8% increase by 2012) workload. Of note is inpatient medicine workload is projected to increase by 40.8% by 2012, and outpatient specialty workload is projected to increase by 129.5% during this same timeframe. The Montgomery campus footprint currently cannot accommodate this projected workload. Because new construction would not begin until approximately 2006, it would be necessary to lease space in the community and contract out the overflow bed days of care (BDOC) in the community until completion. This would create a disruption in the coordination of care and requires the establishment of a strong case management and contract administration program to ensure that patients move smoothly through the full continuum of services offered. The ability to control and manage this type of fragmented operations has the potential of becoming costly and inefficient, not to mention the problems associated with

fragmentation in the coordination of care. This alternative was originally included in the VISN 7 Market Plan because it was thought CAVHCS had no other options. However, with the established union of CAVHCS and Maxwell AFB and the sharing of Maxwell AFB's state-of-the-art facilities (and other military treatment facilities in the CAVHCS service area), it is clear that the most economical method for managing the workload is through a mutually beneficial sharing arrangement with Maxwell AFB. Continued implementation of this sharing arrangement would obviate the need for new construction as included in the VISN 7 Market Plan.

**Status Quo Alternative:** The alternative is not feasible inasmuch as CAVHCS would not be able to meet the projected increases in workload over the next 20 years. The CARES model projects a significant increase in both inpatient and outpatient workload over the next 20 years. CARES veteran data projections indicate a peak need in inpatient acute medicine and MICU beds in FY2012 of 51 beds, and then decreasing slightly to 42 beds in FY2022. The current inpatient bed levels at the Montgomery campus are:

- 32 acute medical beds
- 4 surgical beds
- 7 medical intensive care beds
- 2 surgical intensive care beds

**a. Workload Summary:**

Note: CAVHCS is a fully integrated health care system. Thus, it is not accurate to look at the Montgomery campus only. The first table does not reflect all CAVHCS workload/beds, only the Montgomery campus. Therefore, a second table has been included to appropriately reflect CAVHCS' workload, health care system-wide.

**Montgomery Campus only**

<b>Workload or Space Category</b>	<b>2001 ADC</b>	<b>Baseline Wkld (beds, stops)</b>	<b>2012 Projected Wkld (beds, stops)</b>	<b>2022 Projected Wkld (beds, stops)</b>
Inpatient Medicine	31	36	51	42
Inpatient Surgery	3	6	7	5
Inpatient Psych	0	2	1	1
Inpatient Dom	0	0	0	0
Inpatient NHCU	0	21	23	23
Inpatient PR RTP		-	-	-
Inpatient SCI		-	-	-
Inpatient BRC		-	-	-
Outpatient Primary Care		83,505	91,128	79,378
Outpatient Specialty Care		36,123	83,908	76,388
Outpatient Mental Health		13,455	14,272	14,010
Ancillary & Diagnostics		68,135	98,788	97,057

**Central Alabama Veterans Health Care System (CAVHCS)**

**(Montgomery and Tuskegee Campuses)**

<b>Workload or Space Category</b>	<b>2001 ADC</b>	<b>Baseline Wkld (beds, stops)</b>	<b>2012 Projected Wkld (beds, stops)</b>	<b>2022 Projected Wkld (beds, stops)</b>
Inpatient Medicine	53	103	51	42
Inpatient Surgery	5	10	7	5
Inpatient Psych	45	60	30	30
Inpatient Dom	31	43	43	43
Inpatient NHCU	146	160	160	160
Inpatient PR RTP	-	-	42	42
Inpatient SCI	-	-	-	-
Inpatient BRC	-	-	-	-
Outpatient Primary Care		116,360	129,726	111,565
Outpatient Specialty Care		68,141	100,417	90,037
Outpatient Mental Health		38,265	40,560	39,749
Ancillary & Diagnostics		104,997	137,419	134,671
Geriatrics		5,485	7,548	6,801

**Analysis:**

The Central Alabama Veterans Health Care System (CAVHCS) is comprised of two major sites, the Montgomery campus and Tuskegee campus, and two community-based outpatient clinics (CBOCs) in Columbus, GA and Dothan, AL. The Montgomery and Tuskegee sites have complementary missions. Duplication of services between the Montgomery and Tuskegee campuses was eliminated as a result of the 1997 merger of these two medical centers. Since December 2002, all medical and surgical beds have been completely consolidated at the Montgomery campus. The Montgomery campus currently houses a total of 45 beds. The beds are located in Building 1, which opened in 1940. The structure has been well maintained and is in very good condition.

When considering the feasibility of turning the Montgomery campus into a 8 hour per day operation, it must be noted that the Montgomery campus is the only site within CAVHCS that provides inpatient medicine and surgery services. Moving all the inpatient care to the Tuskegee campus is not a feasible because of its rural location. Thus, the only options for consideration are sending the inpatient workload to other VA medical centers (i.e., Birmingham VAMC or Atlanta VAMC), contracting the inpatient workload in the community, or enhancing the capacity of the Montgomery campus to accommodate the projected workload over the next 20 years. Transferring the inpatient workload to either the Birmingham or Atlanta VAMCs is not feasible since those facilities have no excess capacity. Indeed, those facilities are struggling with large projected workload increases and space shortages. Enhancing the capacity of the Montgomery campus facilities to accommodate future workload is a viable option; however, this alternative would require over \$8 million in new construction. The 100% contract alternative could accommodate projected future inpatient workload, but has been determined to be the least desirable option for several reasons:

1. This alternative would create an inequity in the level of care provided to veterans that CAVHCS serves. Implementation of this alternative would deprive CAVHCS' veterans of VA care while other veterans in VISN 7 and across the country would continue to enjoy the benefits of the second to none VA-delivered care.

2. The 42<sup>nd</sup> Medical Group at Maxwell AFB has no inpatient backup capacity, therefore, closure of CAVHCS' inpatient medicine and surgery capacity would be a severe blow to this DoD installation, including conflicting with the President's Management Agenda's Agency-specific reform, to coordinate VA and DoD programs and systems, as well as recommendations presented by the President's Task Force (PTF) that **VA and DoD can improve quality, access, and efficiency of health care delivery by pooling resources**, eliminating administrative barriers, and implementing change.

3. CAVHCS-operated beds enable a higher degree of control over the costs associated with providing quality inpatient care. CAVHCS-provided inpatient care, coordinated as part of the VA care continuum, is superior to the more fragmented approach of contracting for a portion of the care continuum. Indeed, we estimate a need for a "contract administration and care coordination" office that would handle contract administration, authorizations and payments, and utilization and quality reviews. The recurring costs of this office are estimated at \$618,000.

4. Coordination of care would be adversely impacted. For example, CAVHCS' current inpatient unit allows the seamless transfer of complex surgical candidates (e.g., cardiac surgery) within the VA system. It is unlikely that patients already in the community would be moved to a VA for surgical intervention. This would be costly for VA and may make it more difficult to coordinate surgical aftercare. Additionally, a significant number of CAVHCS' acute medical-surgical admissions consist of patients who are primarily followed in the mental health, geriatrics (including dementia) and substance abuse programs. Currently, care for these patients is closely coordinated and supported/supplemented by mental health and/or geriatrics staff. Moving these patients to community hospitals may be problematic and diminish the quality of care to these patients.

5. Contracting out inpatient medicine and surgery would have a deleterious impact on CAVHCS' academic affiliations.

6. Last, but not least, the 100% contract alternative is not congruent with the President's Management Agenda or Secretary Principi's stated priority to encourage and support VA/DoD sharing initiatives. As indicated in recent statements by Dr. Robert Roswell, Under Secretary for Health, "... acute care services are essential for a robust health care system." Maintaining a high quality continuum of inpatient medicine and surgery services at CAVHCS is in line with Dr. Roswell's desire to improve acute care services in VHA.

**Preferred Alternative:** This leaves the **CAVHCS/DoD sharing alternative** as the best option to assure the continuation of high quality inpatient care to CAVHCS' veterans while maximizing the use of federal resources. CAVHCS is unusual in having three Military Treatment Facilities (MTFs) with its service area. These are:

**Lyster US Army Hospital, Ft. Rucker, Alabama.** The facility is located in an area of high veteran concentration, and approximately 20 miles from clinics that CAVHCS operates in Dothan, Alabama.

**Martin Army Hospital, Ft. Benning, Georgia.** The facility is located approximately 8 miles from the CBOC operated by CAVHCS in Columbus, Georgia. This is also an area of high concentration of veterans and military beneficiaries.

**42<sup>nd</sup> Medical Group, Maxwell AFB, Montgomery, Alabama.** Described in document.

The leadership of each of these MTFs has demonstrated commitment to joint planning for VA and DoD beneficiary services in south and central Alabama and west Georgia as exemplified by:

CAVHCS is already in the process of moving the West Campus Podiatry Clinic to Maxwell AFB. This will provide needed services to Maxwell beneficiaries and provide larger and more efficient space for the Podiatry Residency Program to expand workload for veterans. It will also provide a well-rounded clinical experience for residents.

CAVHCS and the 42<sup>nd</sup> Medical Group submitted a proposal in August 2003, which was approved through all levels of VA and Air Force chains of command, to be one of VA/DoD's nationally funded pilot demonstration sites. The objectives of the proposal are to utilize the implementation of the joint Podiatry venture to establish compatible systems to measure access, cost and quality, and to refine joint planning systems. CAVHCS and the 42<sup>nd</sup> Medical Group are also jointly planning to develop surgical programs, educational programs and, most importantly, ongoing strategic planning.

The VISN 7 Director and the Commanding General of Army's Southeast Regional Medical Command (SERMEC) have jointly chartered a Tiger Team to firmly establish joint VA/DoD planning in the network. The CAVHCS service area, with its three MTFs, has been identified as one market being addressed by this team, further assuring that progress toward a federal health care system in south and central Alabama and west Georgia will be strongly supported.

Military Tri-Care is in the process of reconfiguring its regions. Previously, VISN 7 fell into two of Tri-Care's regions (3&4). Now, VISN 7 will fall entirely in one Tri-Care region. This will allow the Tiger Team to expand to include all branches of service, not just Army. This will further enhance VISN 7's opportunities for joint planning with the military, in which CAVHCS, with its three MTFs, will continue to be a key player.

Commanders of all three MTFs in CAVHCS' service area are meeting regularly with CAVHCS leadership exploring sharing opportunities. In addition to the actions outlined above, other activities include:

Lyster US Army Hospital has recently closed all of its inpatient services, freeing up a significant amount of space. CAVHCS currently leases space in the nearby city of Dothan, and also contracts for primary care services. Talks are underway at both the

MTF level, as well as within the VISN 7 Tiger Team, to explore possible VA/Army sharing of space and services for inpatient and outpatient care in the Dothan/Ft. Rucker area.

CAVHCS has facilitated one sharing agreement with Martin Army Hospital addressing military discharge physicals. Further exploration of needs has identified that Martin Army (which is approximately 8 miles from the CAVHCS CBOC in Columbus, Georgia) may be able to provide certain services for veterans, eliminating waits, travel and/or contracting for certain veteran services. The team is currently looking at certain laboratory tests, radiological studies and women's health care as most urgently needed. A short turnaround time is expected to accomplish sharing agreements in these areas. There is also mutual commitment to continue joint planning for future services in the west Georgia area.

While the future of the Montgomery campus seems on the surface to be most affected by sharing activities with the 42<sup>nd</sup> Medical Group at Maxwell AFB, one cannot ignore the impact of broader VA/DoD sharing across the CAVHCS service area. As services are expanded in the Dothan, Alabama, and Columbus, Georgia areas through sharing agreements, fewer veterans will be required to travel to Montgomery for care. This will not only improve access, but it will free space at the West Campus to allow for growth and sharing opportunities. This space will be added to available space at the Maxwell clinic to provide an outstanding continuum of care for federal beneficiaries in the Montgomery area, and ultimately across the CAVHCS primary service area. It is clear that decisions about one campus with CAVHCS' integrated health care system must take into account planning for the entire system.

This sharing alternative is the best option for veterans, **service members**, and taxpayers for the following reasons:

1. The CAVHCS/DoD sharing alternative facilitates the sharing of federal resources (space, equipment and manpower). Sharing these resources allows CAVHCS to increase its capacity and accommodate projected workload without significant capital investment. The Maxwell AFB facilities are state-of-the-art, recently built in 2000. This is clearly a mutually beneficial arrangement in that CAVHCS gains state-of-the-art space from Maxwell AFB (and other military facilities in the CAVHCS service area), while Maxwell AFB gains high quality care for its service members and backup inpatient capacity from CAVHCS. Since the missions of CAVHCS and Maxwell AFB (and other military facilities in the CAVHCS service area) are complementary to one another, this sharing alternative is a logical and economically prudent approach. Of note is both organizations can begin to reap the benefits of the sharing arrangement immediately in FY 04. CAVHCS is estimated to generate approximately \$12.3 million in revenues from the sharing arrangement with Maxwell AFB. The sharing alternative described in this paper is a continuation of collaborative efforts already underway.

2. About \$8 million in total construction costs would be obviated. The sharing agreement with Maxwell AFB (and other military facilities in the CAVHCS service area) would obviate the estimated \$8 million in new construction included in the VISN 7 Market Plan to address the projected space gap. About \$4 million would still be required to improve some of the Montgomery campus outpatient clinics that are currently operating in former

inpatient ward space. These improvements are required to make the ward space more operationally and clinically efficient for outpatient care.

3. The CAVHCS/DoD sharing alternative directly supports the President's Management Agenda' Agency-specific reform, to coordinate VA and DoD programs and systems, as well as recommendations presented by the President's Task Force (PTF) that **VA and DoD can improve quality, access, and efficiency of health care delivery by pooling resources**, eliminating administrative barriers, and implementing change.

4. This alternative would obviate the inequity in the level of care provided to veterans that would be created under the 100% contract option. Implementation of this alternative would make VA care available to more veterans in VISN 7 and allow them to enjoy the benefits of the second to none VA-delivered care.

5. CAVHCS-operated beds would enable a higher degree of control over the costs associated with providing quality inpatient care. CAVHCS-provided inpatient care, coordinated as part of the VA care continuum, is superior to the more fragmented approach of contracting for a portion of the care continuum.

6. The adverse impact on coordination of care that would occur under the 100% contract alternative would be obviated. For example, CAVHCS' current inpatient unit allows the seamless transfer of complex surgical candidates (e.g., cardiac surgery) within the VA system. It is unlikely that patients already in the community would be moved to a VA for surgical intervention. This would be costly to VA and may make it more difficult to coordinate surgical aftercare. Additionally, a significant number of CAVHCS' acute medical-surgical admissions consist of patients who are primarily followed in the mental health, geriatrics (including dementia) and substance abuse programs. Currently, care for these patients is closely coordinated and supported/supplemented by mental health and/or geriatrics staff. Moving these patients to community hospitals may be problematic and diminish the quality of care to these patients.

7. The deleterious impact the 100% contract alternative would have on CAVHCS' academic affiliations would be obviated.

8. Maxwell AFB is in close proximity to CAVHCS (within seven miles), which means there would be little to no impact on access to care.

9. Last, but not least, the **CAVHCS/DoD sharing alternative** is congruent with the President's Management Agenda and directly supports Secretary Principi's stated priority to encourage and support VA/DoD sharing initiatives. As indicated in recent statements by Dr. Robert Roswell, Under Secretary for Health, "acute care services are essential for a robust health care system". Maintaining a high quality continuum of inpatient medicine and surgery services at CAVHCS is in line with Dr. Roswell's desire to improve acute care services in VHA.

**Description of current programs and services environment:**

**NAME OF FACILITY BEING STUDIED: Montgomery Campus**

<b>Alternate # 1 CAVHCS/DoD Sharing Arrangement</b>					This alternative involves a mutually beneficial sharing arrangement between CAVHCS and Maxwell AFB. This alternative would permit CAVHCS to expand its care capacity without new construction, and permit Maxwell AFB to obtain high quality health care services for its service members.			
<b>Workload or Space Category</b>	<b>2001 ADC for IP</b>	<b>Baseline workload from Millman for beds &amp; stops</b>	<b>2012 Projected Wkld (beds, stops)</b>	<b>2022 Projected Wkld (beds, stops)</b>	<b>% to be transferred</b>	<b>Year to begin transfer</b>	<b>Receiving Facility Name</b>	<b>Receiving Facility % contracted out</b>
Inpatient Medicine	31	36	55	46	0	2004	Montgomery	
Inpatient Surgery	3	6	10	8	0	2003	Montgomery	
Inpatient Psych	0	2	1	1	100%	2002	Tuskegee	
Inpatient Dom	0	0	0	0				
Inpatient NHCU	0	21	23	23	100%	2002	Tuskegee	
Inpatient PR RTP								
Inpatient SCI								
Inpatient BRC								
Outpatient Primary Care		83,505	140,457	129,679	0	2004	Montgomery	
Outpatient Specialty Care		36,123	124,268	121,232	0	2004	Montgomery	
Outpatient Mental Health		13,455	14,272	14,010	0	2004	Montgomery	
Ancillary & Diagnostics		68,135	98,788	97,057	0	2004	Montgomery	
Research SPACE	N/A		N/A	N/A				
Admin SPACE	N/A		N/A	N/A				
Other SPACE	N/A		N/A	N/A				

Note: CAVHCS is a fully integrated health care system. Thus, it is not accurate to look at the Montgomery campus only. The first table does not reflect all CAVHCS workload/beds, only the Montgomery campus. Therefore, a second table has been included to appropriately reflect CAVHCS workload, health care system-wide.

**NAME OF FACILITY BEING STUDIED: Montgomery Campus**

<b>Alternate # 1 CAVHCS/DoD Sharing Arrangement</b>					This alternative involves a mutually beneficial sharing arrangement between CAVHCS and Maxwell AFB. This alternative would permit CAVHCS to expand its care capacity without new construction, and permit Maxwell AFB to obtain high quality health care services for its service members.			
<b>Workload or Space Category</b>	<b>2001 ADC for IP</b>	<b>Baseline workload from Millman for beds &amp; stops</b>	<b>2012 Projected Wkld (beds, stops)</b>	<b>2022 Projected Wkld (beds, stops)</b>	<b>% to be transferred</b>	<b>Year to begin transfer</b>	<b>Receiving Facility Name</b>	<b>Receiving Facility % contracted out</b>
Inpatient Medicine	53	103	55	46	0	2004	Montgomery	
Inpatient Surgery	5	10	10	8	0	2003	Montgomery	
Inpatient Psych	45	60	1	1	100%	2002	Tuskegee	
Inpatient Dom	31	43	43	43				
Inpatient NHCU	146	160	160	160	100%	2002	Tuskegee	
Inpatient PR RTP								
Inpatient SCI								
Inpatient BRC								
Outpatient Primary Care		83,505	165,689	161,866	0	2004	Montgomery	
Outpatient Specialty Care		36,123	108,501	134,881	0	2004	Montgomery	
Outpatient Mental Health		13,455	14,272	14,010	0	2004	Montgomery	
Ancillary & Diagnostics		68,135	98,788	97,057	0	2004	Montgomery	
Research SPACE	N/A		N/A	N/A				
Admin SPACE	N/A		N/A	N/A				
Other SPACE	N/A		N/A	N/A				

The second table reflects the additional 4-inpatient medicine and 3-inpatient surgery average daily census (ADC) from Maxwell AFB. It should be noted that the current total bed capacity on the Montgomery campus is 45 beds. This means that without the additional Maxwell AFB workload, CAVHCS would still need to increase its inpatient capacity by 6 beds by 2012 to accommodate the projected 22% increase in inpatient workload. To accommodate the projected 2012 CAVHCS

workload plus the total of seven ADC from Maxwell AFB, CAVHCS will need to increase its total inpatient bed capacity by 13 beds from the current level of 45 beds. Under the CAVHCS/CAVHCS sharing arrangement, the required increased capacity can be obtained from within current shared space (shared with three military facilities in the CAVHCS service area), obviating the need for new construction.

The table also reflects the additional Maxwell AFB outpatient workload projected under the CAVHCS/DoD sharing alternative. The projected combined workload (inpatient medicine and surgery) from Maxwell AFB in 2012 will be 89,689 clinic stops, and 95,145 clinic stops in 2022. Again, under the CAVHCS/DoD sharing alternative, this workload can be accommodated within the joint resources of CAVHCS and Maxwell AFB (and other military facilities in the CAVHCS service area). Additionally, the revenue generated from the Maxwell AFB workload is expected to be approximately \$12.3 million annually. These additional dollars will directly enhance CAVHCS' ability to provide the excellent health care to veterans for which it is known.

**Travel times:** The CAVHCS/DoD sharing alternative improves access to care for both primary care and acute care. Note in the 100% contract alternative the acute care access percentage increased due to contracts with community hospitals in Columbus and Opelika, in addition to the ones identified in the VISN 7 Market Plan in Dothan and Huntsville, Alabama.

#### VISN 7 Market Plan

Type	Current Access %	New Access %
Primary Care	62%	72%
Acute Care	53%	65%

#### 100% Contract

Type	Current Access %	New Access %
Primary Care	62%	72%
Acute Care	53%	80%

#### CAVHCS/DoD Sharing

Type	Current Access %	New Access %
Primary Care	62%	72%
Acute Care	53%	65%

**Current physical condition of the realignment site and patient safety:** The Montgomery campus originally housed 200 beds. It currently houses a total of 45 inpatient medicine and surgery beds. The beds are located in Building 1, which opened in 1940. The structure has been well maintained and is in very good condition. There are no notable patient safety issues. The Montgomery campus is a viable cost effective location for inpatient services. The average facility condition score is 3.4 on a scale of 1-5, with 5 being the best possible score. Both patient care and administrative service areas are in above average condition. Inpatient medicine and surgery space is in particularly good condition with an average score of 4.0 for medicine and 3.8 for surgery. On the other hand, the Tuskegee campus has an average condition score of 2.5. With minor renovations to reconfigure space for outpatient operations, the Montgomery campus infrastructure is well suited to meet the projected veteran demand for health care over the next 20 years.

The VISN 7 CARES market plan indicates 59,000 square feet of new construction at the Montgomery campus would be required to accommodate the future projected inpatient workload for medicine, specialty care, and ancillary/diagnostic. The estimated cost of the new construction is about \$8 million. Under the CAVHCS/DoD sharing alternative, the need for the new construction would be obviated.

The Montgomery campus has minimal vacant space as depicted in the below tables. Compounding this, currently, the Montgomery campus has no vacant buildings. Therefore, to accommodate the CARES projected workload, additional capacity will be sought through sharing arrangements with the three military facilities in the CAVHCS service area. Although the Tuskegee campus has a significant amount of vacant space, most of it is in poor condition (average condition score of 2.5 on a scale of 1-5, with 5 being the best) and, due to its rural location, the site is not an appropriate location for acute inpatient operations. Therefore, the vacant Tuskegee space is not a viable consideration for accommodating the CARES projected workload.

2001 Baseline Data		Name of Facility Being Studied: CAVHCS Montgomery Campus						
Facility Name	Campus Acreage	Original Bed Capacity (Beds)	Number of Vacant Bldgs	Number of Occupied Bldgs	Vacant Space (SF)	Average Condition Score	Annual Capital Costs *	Valuation of Campus (AEW)
Montgomery	50	200	1	22	2,157	3.4	\$2,747,795	\$61,000,000
Tuskegee	187	600	17	32	265,672	2.5	\$4,511,562	\$118,800,000

## Impact considerations:

### Summary NEW

Capital Costs Summary	Status Quo	Original Market Plan	100% Contract	Alternate 1
Facility Being Reviewed: CAVHCS - West Campus				
New Construction	-	\$ 7,903,556	\$ 6,069,181	\$ 0
Renovation	-	\$ 5,995,336	\$ 4,591,919	\$ 6,145,951
Total	-	\$ 13,898,892	\$ 10,661,100	\$ 6,145,951
Receiving Facility 1: CAVHCS - East Campus				
New Construction	-	-	\$ 0	\$ 0
Renovation	-	\$ 11,932,658	\$ 11,932,658	\$ 11,932,658
Total	-	\$ 11,932,658	\$ 11,932,658	\$ 11,932,658

Under the Market Plan new construction is included for specialty care, ancillary services and acute medicine. New acute medicine would not be included in the 100% (inpatient) contract option. The DoD sharing alternative would eliminate the need for any new construction at Montgomery. The above table shows the CAVHCS/DoD sharing alternative would require the least capital investment of the alternatives examined, over \$7 million less than the 100% contract alternative, and over \$8 million less than the VISN 7 Market Plan.

### NEW SUMMARY

Operational Costs Summary	Status Quo	Original Market Plan	100% Contract	Alternate 1
Facility Being Reviewed: CAVHCS - West Campus				
Operating Costs	\$ 1,144,778,973	\$ 1,199,906,501	\$ 813,967,629	\$ 1,486,728,793
Receiving Facility 1: CAVHCS - East Campus				
Operating Costs	\$ 1,472,773,911	\$ 1,290,142,638	\$ 1,782,824,143	\$ 1,290,142,645

### Combined Total

\$2,490,049,139      \$2,596,791,772      \$2,776,871,438

\*Unadjusted by DoD revenue stream.

**Human resources:** Under the preferred CAVHCS/DoD sharing alternative, there would be no need for a reduction in staffing; thus, no negative impact on human resources. On the other hand, if the 8 hour/day operation alternative was implemented it is

estimated that approximately 59 FTEE would have to be reduced. This estimate of 59 FTEE is a net loss figure, since ~67 of the total 126 FTE now supporting inpatient medicine and surgery, and the life support unit (LSU) would need to be shifted to the outpatient programs in order to adequately staff the CARES projected outpatient workload increases. This rightsizing would have to occur through attrition and would be a lengthy process since the Montgomery area does not have a nursing shortage and the staffing history has been one of low turnover. There are some support areas (e.g., EMS, Imaging and Lab) that would experience a decrease in inpatient workload, but the 43% projected increase in outpatient workload is so significant that it more than offsets any potential reductions in those areas. Most other support functions will not realize a significant reduction in workload because the majority of their workload is performed during daytime working hours.

Under the 100% contract alternative, it is estimated that about 10% of those employees affected by the staffing reductions (displaced inpatient employees who are shifted to support outpatient operations) would require relocation reimbursement congruent with VA regulations. Relocation costs for these displaced employees could exceed \$650,000. It should be noted that this potential cost was not included in the cost spreadsheets.

The CAVHCS/DoD sharing alternative permits VA employees to retain their jobs and continue providing the excellent care for which they are known. Some increase in FTE would be necessary to accommodate the projected Maxwell AFB workload. However, CAVHCS would benefit from a significant portion of the estimated \$12.3 million in annual revenues from the sharing arrangement.

**Patient care issues and specialized programs:** Clearly, under the 100% contract alternative the most obvious major adverse impact would be on coordination of care. Currently, the Montgomery campus inpatient units can seamlessly transfer certain complex (e.g., cardiac surgery) surgical candidates within the VA system. However, under the 100% contract scenario, it is unlikely that patients already in the community would be moved to a VA for this type of surgical intervention. This would be much more costly to VA and would make it much more difficult to assure appropriate post-surgery aftercare coordination.

A further negative impact of the 100% contract alternative would be on those veterans who may experience medical care co-payments as a result of receiving care in the community when they may not have been subject to a co-payment with VA. If a veteran in Priority Group 5 is seen after hours and does not meet criteria for payment under any VA program, he/she may be charged a Medicare or insurance deductible. Had VA provided the care he/she would not have incurred those charges. The current Medicare co-payment is \$812. In FY 2002 CAVHCS experienced 663 after-hours admissions for Priority Group 5 patients. This alternative is clearly shifting the cost burden for the co-payment to this group of patients.

The 100% contract alternative would also create an inequity in the level of care provided to those veterans that CAVHCS serves. Implementation of this alternative would deprive CAVHCS' veterans of VA care while other veterans in VISN 7 and across the

country would continue to enjoy the benefits of VA care. With no cost advantage, implementation of the 100% contract alternative would be without merit since it would not improve the care provided to the veterans CAVHCS serves.

In addition, under the 100% contract alternative the following clinical areas would be severely impacted:

1. CAVHCS has an active surgery program with four general surgeons, a full time urologist, full time orthopedist, full time ophthalmologist, and fee basis surgeons in orthopedics and urology. The number of surgical procedures has been steadily increasing. In FY 03, the number of outpatient surgical procedures increased by 25% over FY 02. The entire surgery program would be compromised if the inpatient surgery program were contracted out. It would not be possible to keep well-qualified surgeons and a viable surgical program if acute care services were not also available. Surgeons are unable to maintain their skills if only ambulatory surgery is provided and, therefore, would likely not be interested in employment in a facility without inpatient services. Subsequently, if CAVHCS lost its surgeons and, thus, lost its entire surgery program, the cost of purchasing the outpatient surgical workload in the community must also be figured into the analysis. The cost of contracting out the surgery workload may be understated inasmuch as the analysis does not include the cost of purchasing the outpatient surgery workload in addition to the inpatient workload.

2. CAVHCS has an active podiatry program with four podiatry residents. Since the podiatry residents need experience in acute and inpatient services to achieve well-rounded training, a podiatry residency program could not be sustained at CAVHCS if these services were not available.

3. Elimination of acute care services at CAVHCS would result in the Birmingham VAMC being the only acute care VA facility in Alabama. Due to the distance (~2 hours away), it is not feasible to send patients for acute care needs to Birmingham. Moreover, the Birmingham VAMC cannot accommodate the increased workload from CAVHCS because it is land locked and has no capability to expand.

4. Nursing home and mental health patients have very special needs. A significant number of CAVHCS' acute medical-surgical admissions consist of patients who are primarily followed in the mental health, geriatrics (including dementia) and substance abuse programs. Currently, care for these patients is closely coordinated and supported/supplemented by mental health and/or geriatrics staff. Moving these patients to community hospitals under the 100% contract alternative would be problematic and would diminish the quality of care they are currently accustomed to receiving. Trying to accommodate their needs in community facilities when they develop acute problems would be quite difficult, if not impossible.

5. With the increasing deployment demands on Maxwell AFB, it would be very beneficial for CAVHCS staff to work with Maxwell AFB, which currently functions as the equivalent of VA's Austin.

**Impact on Research and Academic Affairs:** CAVHCS has the following academic affiliations:

- Medical Affiliation: Morehouse School of Medicine in Psychiatry and Internal Medicine/Geriatrics
- Podiatry Affiliations: Scholls College of Podiatric Medicine, Barry College of Podiatric Medicine
- Associated Health Professions Affiliations (Nursing): Auburn University/Auburn University in Montgomery, University of Alabama, Troy State University, Tuskegee University and Southern Union Technical College
- Physical Therapy – Alabama State University
- Occupational Therapy – Tuskegee University
- Pharmacy – Auburn University
- Dietetics – University of Alabama in Birmingham
- Social Work – Auburn University, University of Alabama, University of Alabama in Birmingham, Tuskegee University
- Recreational Therapy – Alabama State University

Loss of the inpatient medical and surgical services would restrict CAVHCS' ability to continue to offer well-rounded training and educational experiences for residents, nursing students and others in the health care field. For instance, surgeons would be unable to acquire or maintain their skills if only ambulatory surgery is provided. CAVHCS currently has a very active podiatry program with four podiatry residents. Since the podiatry residents need experience in acute and inpatient services to achieve well-rounded training, a podiatry residency program could not be sustained at CAVHCS if these services were not available.

**Reuse of the Realigned Campus:** Not applicable

**Summarize alternative analysis:**

NAME OF FACILITY BEING STUDIED: CAVHCS (Montgomery Campus)

<p><b>Preferred alternative description and rationale</b></p>	<p>The <b>CAVHCS/DoD sharing alternative</b> was determined to be the preferred option. This alternative was selected as the preferred option because it maximizes the use of federal resources (space, equipment and manpower) to provide health care services to veterans and service members in the Montgomery area, while at the same time allowing both VA and DoD to assure high quality of services across the health care continuum. Revenue from this sharing arrangement is projected to be \$12.3 million annually.</p> <p>The CAVHCS/DoD sharing alternative directly supports the President's Management Agenda Agency-specific reform, to coordinate VA and DoD programs and systems, as well as recommendations presented by the President's Task Force (PTF) that <b>VA and DoD can improve quality, access, and efficiency of health care delivery by pooling resources</b>, eliminating administrative barriers, and implementing change.</p> <p>This alternative would obviate the inequity in the level of care provided to veterans that would be created under the 100% contract option.</p> <p>The adverse impact on coordination of care that would occur under the 100% contract alternative would be obviated. CAVHCS' current inpatient units seamlessly transfer complex surgical candidates (e.g., cardiac surgery) within the VA system. It is unlikely that patients already in the community would be moved to a VA for surgical intervention. This would be more costly to VA and likely make the coordination of surgical aftercare more difficult. Additionally, a significant number of CAVHCS' acute medical-surgical admissions consist of patients who are primarily followed in the mental health, geriatrics (including dementia) and substance abuse programs. Currently, care for these patients is closely coordinated and supported/supplemented by mental health and/or geriatrics staff. Moving these patients to community hospitals may be problematic and diminish the quality of care to these patients.</p> <p>The deleterious impact the 100% contract alternative would have on CAVHCS' academic affiliations would be obviated.</p> <p>Maxwell AFB is in close proximity to CAVHCS (within seven miles), which means there would be little to no impact on accessibility to care.</p> <p>Last, but not least, the CAVHCS/DoD <b>sharing</b> alternative is congruent with the President's Management Agenda and directly supports Secretary Principi's stated priority to encourage and support VA/DoD sharing initiatives. As indicated in recent statements by Dr. Robert Roswell, Under Secretary for Health, "acute care services are essential for a robust health care system". Maintaining a high quality continuum of inpatient medicine and surgery services at CAVHCS is in line with Dr. Roswell's desire to improve acute care services in VHA.</p>
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	Status Quo	Original Market Plan	100% Contract	CAVHCS/DoD Sharing
<p><b>Short description</b></p>	<p>This alternative is not feasible inasmuch as CAVHCS would not be able to meet the projected increases in workload over the next 20 years. The CARES model projects a significant increase in both inpatient and outpatient workload over the next 20 years. CARES veteran data projections indicate a peak need in inpatient acute medicine and MICU beds in FY2012 of 51 beds, and then decreasing slightly to 42 beds in FY2022. The current inpatient bed levels at the Montgomery campus are:</p> <ul style="list-style-type: none"> <li>• 32 acute medical beds</li> <li>• 4 surgical beds</li> <li>• 7 medical intensive care beds</li> <li>• 2 surgical intensive care beds</li> </ul>	<p>This alternative calls for new construction to accommodate the significant increase in overall projected inpatient (21.9% increase by 2012) and outpatient (42.8% increase by 2012) workload. Of note is inpatient medicine workload is projected to increase by 40.8% by 2012, and outpatient specialty workload is projected to increase by 129.5% during this same timeframe. The Montgomery campus footprint currently cannot accommodate this projected workload. Because construction would not begin until approximately 2006, it would be necessary to lease space in the community and contract out the overflow bed days of care (BDOC) in the</p>	<p>The 100% contract alternative consists of converting the Montgomery campus from a 24/7 operation to an 8-hour/day operation. This scenario entails contracting out 100% of CAVHCS' inpatient medicine and surgery workload to the community, which would require acute inpatient medicine and surgery, and the medical intensive care unit (MICU) being shifted to a contract facility.</p>	<p>The CAVHCS/DoD sharing alternative facilitates the sharing of federal resources (space, equipment and manpower). Sharing these resources allows CAVHCS to increase its capacity and accommodate projected workload without significant capital investment. The Maxwell AFB facilities are state-of-the-art, recently built in 2000. This is a mutually beneficial arrangement in that CAVHCS gains state-of-the-art space from Maxwell AFB, while Maxwell AFB gains high quality care for its service members and backup inpatient capacity from CAVHCS. Since the missions of CAVHCS and Maxwell AFB are complementary to one another, this sharing alternative is a logical approach. Of note is both organizations can begin to reap the benefits of the sharing arrangement immediately in FY 04.</p> <p>About \$8 million in construction costs would be obviated. This sharing arrangement with Maxwell AFB would offset the estimated \$8 million in new construction included in the VISN 7 market plan to address the projected space gap. Approximately \$4 million in</p>

		community until completion. This would create a disruption in the coordination of care and requires the establishment of a strong case management and contract administration program to ensure that patients move smoothly through the full continuum of services offered.		renovation would still be required at the Montgomery campus to improve the outpatient clinics to make them more efficient.
<b>Total Construction Costs (CAVHCS – West)</b>	-	\$ 13,898,892	\$ 10,661,100	\$ 6,145,951
<b>Life Cycle Costs (combined West &amp; East)</b>	\$ 2,736,149,568	\$2,518,374,935	\$2,621,879,776	\$2,632,232,757
<b>Impact on Access</b>	Negative impact on access for future projected additional workload. Current inpatient bed level would not accommodate future additional projected workload.	No negative impact on access. New construction would create capacity to accommodate future additional projected workload.	Positive impact on access. Veterans could access inpatient medicine and surgery services at community health care facilities closer to their homes.	No negative impact on access. Sharing Maxwell AFB space would create capacity to accommodate additional projected workload without cost of new construction.
<b>Impact on Quality</b>	No impact on quality of care provided to veterans currently enrolled. VA capacity would not be available to accommodate additional projected workload.	No long-term impact on quality of care. Temporary negative impact on quality may occur if interim contract care is used until completion of new construction.	Negative impact on quality of care. Coordination of care would be adversely impacted. CAVHCS' current inpatient units allow the seamless transfer of complex surgical candidates (e.g., cardiac surgery) within the VA system. It is unlikely that patients already in the community would be moved to a VA for surgical intervention. In addition to being costly, coordination of surgical aftercare would be more difficult. Additionally, a significant number of CAVHCS' acute medical-surgical admissions consist of patients who are primarily followed in the mental health, geriatrics (including dementia) and substance abuse programs. Currently, care for these patients is closely coordinated and supported/supplemented by mental health and/or geriatrics staff. Moving these patients to community hospitals would be problematic and diminish the quality	No impact on quality of care. Current and future projected workload would continue to receive high quality VA care.

			of care to these patients.	
<b>Impact on Staffing &amp; Community</b>	No impact on staffing or community. Current staffing levels would be maintained.	No impact on staffing or community. Staffing levels would be enhanced to accommodate future projected workload.	Negative impact on staffing. This alternative would require the reduction of about 59 FTEE over a period of time. These staff would be lost through attrition. CAVHCS would have to bear the additional cost, over and above the contract costs, of these staff inasmuch as the attrition period is projected to be lengthy.	No impact on staffing or community. Staffing levels would be enhanced to accommodate future projected workload.
<b>Impact on Research &amp; Education</b>	No impact on research or education. CAVHCS currently does not have a research program.	No impact on research. CAVHCS currently does not have a research program. Positive impact on education. Having acute inpatient services will enable the surgeons to maintain their skills. CAVHCS has an active Podiatry Program and the residents need acute services and inpatient services to achieve well-rounded training.	No impact on research. CAVHCS currently does not have a research program. Negative impact on education. Not having acute inpatient services will limit the scope of practice for surgeons and residents who need these services to maintain their skills and/or round out their training experiences.	No impact on research. CAVHCS currently does not have a research program. Positive impact on education. Maxwell AFB will require additional acute inpatient care (provides a varied case-mix) and CAVHCS will have the benefit of sharing their state-of-the-art facilities.
<b>Optimizing Use of Resources</b>	Negative impact since future demand will significantly exceed current capacity and resource availability.	Negative impact in part since it does not include the collaborations with Maxwell AFB (and other military facilities in the CAVHCS service area), which will not only optimize the use of resources; but will generate about \$12.3 million in revenue annually.	Negative impact. CAVHCS-operated beds would enable a higher degree of control over the costs associated with providing quality inpatient care. CAVHCS-provided inpatient care, coordinated as part of the VA care continuum, is superior to the more fragmented approach of contracting for a portion of the care continuum.	Very positive impact and enables both CAVHCS and Maxwell AFB (and other military facilities in the CAVHCS service area) to optimize utilization of resources through sharing of space, equipment and manpower. CAVHCS is projected to generate about \$12.3 million annually from the sharing agreement with Maxwell AFB.
<b>Support other Missions of VA</b>	No impact.	No impact.	No impact.	Positive impact. This alternative supports the President's Management Agenda and the President's Task Force recommendations to coordinate VA and DoD programs and systems.
<b>Other significant considerations</b>	N/A	N/A	A further negative impact would be veterans who may experience medical care co-payments as a result of receiving care in the community, which they may not have been subject to with VA.	For more than two decades, Congress and Presidents have tried to increase collaboration and sharing between VA and DoD in order to improve the efficiency and cost effectiveness of health care delivery for beneficiaries. *

\*Excerpt from the Brief Guide to the Final Report from the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans.